Hawaii Employer-Union Health Benefits Trust Fund (EUTF)

Declaration of Termination of Domestic Partnership

I. DECLARATION

I, _____, an employee-beneficiary of the EUTF or a former domestic partner of an employee-beneficiary of the EUTF, declare that, as of _____ (date), am no longer in a domestic partnership with _____ because:

☐ our domestic partnership no longer meets all the status criteria set forth in our declaration of domestic partnership, or

☐ the domestic partner deceased as of _____ (date), or

☐ our domestic partnership terminated or dissolved as of _____ (date).

II. TERMINATION OF COVERAGE

I understand that termination of coverage of the domestic partner and the domestic partner's dependent children, if any, will be effective upon the EUTF's receipt of this Declaration.

I affirm, under penalty of perjury, that the statements in this Declaration are true and correct.

_____ _____

Employee-Beneficiary Signature (or former Domestic Partner's Signature) Date

_____ _____

_____ _____

Employee-Beneficiary Address Domestic Partner Address